STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445487	A. BUILDING _____ B. WING	05/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE CENTER OF JOHNSON CITY, INC	140 TECHNOLOGY LANE JOHNSON CITY, TN 37604

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and complaint investigation #35859 were completed on May 26-28, 2015, at Christian Care Center of Johnson City. No deficiencies were cited related to complaint investigation #35859. F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 000	Preparation and/or execution of this Plan of Correction does not constitute an admission or agreement by Christian Care Center of Johnson City of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. Christian Care Center of Johnson City files this Plan of Correction solely because it is required to do so for continued state licensure as a health care provider and/or for participation in the Medicare/Medicaid program. The facility does not admit that any deficiency existed prior to, at the time of, or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal and any other applicable legal or administrative proceedings. This Plan of Correction should not be taken as establishing any standard of care, and the facility submits that the actions taken by or in response to the survey findings far exceed the standard of care. This document is not intended to waive any defense, legal or equitable, in administrative, civil or criminal proceedings.	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer Mackey MPH, NHA	Administrator	6/10/2015

Any deficiency statement ending with an asterisk (*)denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to notify the physician of a resident's change in condition and death, for one resident (#101) of 38 residents reviewed. The findings included: Medical record review revealed Resident #101 was re-admitted to the facility on 2/23/15 with diagnoses including Metastatic Prostate Cancer, Stage IV, Extensive Bony Metastasis, Anasarca, Hypertension, Paroxymal Atrial Fibrillation, Bilateral Nephrostomy, and a Stage III Pressure Wound to the Coccyx. Review of facility policy, Charting and Documentation, date revised 6/2014, revealed "1. Chart all pertinent changes in the Resident's condition...4...c. Chart on all shifts for the first three [3] days...Miscellaneous: 1. Documentation should also include any time the physician or family is called about the resident, as well as their response...Death of a Resident: 1. Documentation pertaining to the death of a resident includes: a. Pertinent information before death [i.e. symptoms, vital signs, treatment, etc.] b. date and time of death. c. Name of physician notified and when notified..." Medical record review of the Interdisciplinary Progress Notes revealed "2/23/2015 4:30p [PM] Resident arrived at the facility from...MC [Local Medical Center] via stretcher escorted by EMS	F 157	**Corrective Actions for Targeted Residents** Resident #101 no longer resides at the facility **Identification of Other Residents with Potential to be Affected** Residents experiencing a change in condition or are experiencing the dying process, including death, have the potential to be affected by this practice. After reviewing the 24-Hour Nursing Shift Report and per Nursing Rounds observations on 5/28/15 (last day of Annual Survey), no other residents were identified as experiencing a change in condition or experiencing the dying process that would warrant physician notification. **Systematic Changes** Mandatory in-service will be conducted on 6/12/15 by the DON and ADON for Nursing Staff regarding the need to notify the physician with any change in residents' condition or when residents are experiencing the dying process, including death. This education included documentation of residents' change in condition on the 24-Hour Nursing Shift Report for communication to Administrative Staff. This in-service will be repeated on 6/26/15 by the DON and ADON to ensure Nursing Staff is educated. Newly-hired nurses will be educated by ADON during their orientation period regarding the	

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F 157	Continued From page 2 [Emergency Medical Services]. Resident is alert & oriented x 3 [person, place, time]...VS [vital signs]102/93 P [pulse]78...Denies pain or discomfort...Resident requires asst x 2 for ADLS [resident required the assistance of 2 staff for activities of daily living]..." Continued medical record review revealed the next entry was a nurse's note dated 2/25/15 at 0754 [39 hours 24 minutes and 4 shifts later] "...While CNA [Certified Nursing Assistant] was taken am [morning] meal into room she returned to this writer et [and] we entered this room et noted Res without respiration et pulse...ADON [Assistant Director of Nursing] aware, Res family aware. No obtainable vital signs. Modeling [mottling] noted in facial, B/L U +LE [bilateral upper and lower extremities] LPN [Licensed Practical Nurse] #2..." Further medical record review revealed a nurse's note, dated and timed 2/23/15 at 0754, "Entered resident 's room with [LPN #2] no visible respirations. No obtainable VS [vital signs]. Skin pale, cool to touch. Pronounced @ 0754 [pronounced dead at 7:54 AM]...RN, ADON [Registered Nurse, Assistant Director of Nursing]." Telephone interview with the physician called by the Administrator on 5/28/15 at 1100 AM, in the conference room confirmed the physician remembered the resident but did not remember the specific circumstances related to his death. Interview with the Director of Nursing on 5/28/15 at 12:10 PM, in the DON's office confirmed the facility policy and expectation is that a resident's change in condition, time of notification, name of	F 157	F 157 Cont. need to notify the physician with any change in residents' condition or when residents are experiencing the dying process, including death. **Monitoring** Daily Nursing 24-Hour Report Sheets will be audited every morning by the DON and the ADON to ensure the physician was notified of any report of a resident's change in condition or when a resident has expired in the facility. A monthly audit from these findings will be conducted by the DON and ADON for residents experiencing a change in condition or have expired in the facility to ensure the physician was notified. The results of this audit will be presented by DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until the goal of 100% compliance is met for 3 consecutive months; then quarterly. The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	6-30-15

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F 157	Continued From page 3 the person notified should have been documented in the medical record, and there was no record of the physician being notified of a change in the resident's condition or death.	F 281	**Corrective Actions for Targeted Residents** The Family Nurse Practitioner wrote an order for the cited eye drops for Resident #20 on 5/27/15. Resident #20 showed no ill effects from the eye drop administration. **Identification of Other Residents with Potential to be Affected** Facility residents have a potential to be affected by this practice. During monthly MAR change-over on 5/31/15, all residents' MARs were checked by a Licensed Nurse to ensure there is a transcribed order for each medication given. This MAR monthly change-over was co-signed by a second nurse to ensure transcription accuracy of MAR. LPN #1 was counseled on 5/27/15 by the DON regarding the need to have a transcribed order documented on the MAR for any medication administered to a resident. **Systematic Changes** Mandatory in-service will be conducted for the Nursing Staff on 6/12/15 by the DON and ADON regarding the need to administer only medications with a transcribed order on the MAR to facility residents. This in-service will be repeated on 6/26/15 by the DON and ADON to ensure the Nursing Staff is educated.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to obtain a physician's order to dispense a PRN (as needed or requested) medication for one resident (#20) of 13 residents observed during medication administration. The findings included: Observation on 5/27/15 at 1:15PM, in the resident's room revealed the Licensed Practical Nurse (LPN #1) removed the stock eye drops from the medication cart and administered 2 eye drops into each of the resident's eyes. Medical record review of the Medication Administration Record dated 5/1/15, with LPN #1, revealed no order was transcribed for the eye drops. Interview with LPN #1, on 5/27/2015 at 1:40PM, in front of the resident's room confirmed the resident had requested the eye drops, the LPN had given them in the past, and "was sure" the resident had a PRN order for the eye drops.			

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F 281	Continued From page 4 Medical record review of the Physician's Orders dated 5/1/2015 and the facility Standing Orders revealed no order for eye drops for the resident. Interview with the Family Nurse Practitioner on 5/27/2015 at 3:30 PM, in the conference room confirmed there was no current order for the eye drops for Resident #20.	F 281	Newly-hired nurses will be educated by the ADON during their orientation period regarding the need to administer only medications with a transcribed order on the MAR to facility residents. Consultant Pharmacist will perform a Medication Administration Observation Audit of nurses during their monthly compliance visits to ensure each medication has a transcribed order present on the MAR. **Monitoring** A monthly Medication Administration Observation Audit of nurses will also be conducted by DON and ADON to ensure each medication administered has an order transcribed onto the MAR for the medication. Also, 100% audit will be conducted during the monthly MAR change-over and verified by two licensed nurses. The results of these audits will be presented by the DON to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until the goal of 100% compliance is met for 3 consecutive months; then quarterly. The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	6-30-15
F 514 SS=D	483.75(1)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on facilty policy review, medical record review and interview, the facility failed to maintain a complete and accurate medical record for one resident (#101) of 38 residents reviewed. The findings included: Medical record review revealed Resident #101 was re-admitted to the facility on 2/23/15 with diagnoses including Metastatic Prostate Cancer,			

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F 514	Continued From page 5 Stage IV, Extensive Bony Metastasis, Anasarca, Hypertenion, Paroxymal Atrial Fibrillation, Bilateral Nephrostomies, and a Stage III Pressure Wound to the Coccyx. Review of facility policy, Charting and Documentation, date revised 06/2014, revealed "1. Chart all pertinent changes in the Resident's condition...4. New Admission- c. Chart on all shifts for the first three (3) days...Miscellaneous: 1. Documentation should also include any time the physician or family is called about the resident, as well as their response...Death of a Resident: 1. Documentation pertaining to the death of a resident includes: a. Pertinent information before death (i.e. symptoms, vital signs, treatment, etc.) b. date and time of death. c. Name of physician notified and when notified..." Medical record review of the Interdisciplinary Progress Notes revealed, "2/23/15 4:30 p [PM] Resident *arrived* at the facility from..MC [Local Medical Center] via stretcher escorted by EMS [Emergency Medical Services]. Resident is alert & oriented x 3 [person, place, time]...VS [vital signs]102/93 P [pulse] 78...Denies pain or discomfort...Resident requires asst x 2 for ADLS [resident required the assistance of 2 staff for activities of daily living]..." Continued medical record *review revealed* a nurse's note dated "2/25/15 0754 [7:54AM, 39 hours 24 minutes and 4 shifts later] While CNA [Certified Nursing Assistant] was taken am [morning] meal into room she returned to this writer et [and] we entered this room et noted Res without respiration et pulse...ADON [Assistant Director of Nursing] aware, Res family aware. No obtainable vitals signs. Modeling [mottling] noted	F 514	<u>Corrective Actions for Targeted Residents</u> Resident #101 no longer resides at the facility. <u>Identification of Other Residents with Potential to be Affected</u> Facility residents have the potential to be affected by this practice. After reviewing the 24-Hour Nursing Shift Report and per Nursing Rounds observations on 5/28/15 (last day of Annual Survey), no other residents were identified as experiencing a change in condition that would require additional documentation and notifications of family and physician. <u>Systematic Changes</u> Mandatory in-service will be conducted on 6/12/15 by the DON and ADON for Nursing Staff addressing the facility Charting and Documentation Policy. This includes following facility policy for routine charting, the need to document in the medical record any pertinent changes in residents' condition, and times of notifications of family and physician. This in-service will be repeated on 6/26/15 by the DON and ADON to ensure Nursing Staff is educated.	

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F 514	Continued From page 6 in facial, B/L U +LE [bilateral upper and lower extremities]...LPN #2" Further medical record review revealed a nurse's note, dated and timed 2/23/2015 at 0754 (7:54 AM), "Entered Resident 's room with [LPN #2] no visible respirations. No obtainable VS [vital signs]. Skin pale, cool to touch. Pronounced @ 0754 [pronounced dead at 7:54 AM]...RN, ADON [Registered Nurse, Assistant Director of Nursing]." Interview with the Administrator and LPN #2 on 5/28/15 at 10:00 AM, in the conference room confirmed LPN #2 worked day shift 2/24/15 and 2/25/15, but the doctor saw the resident on 2/24/15, had the chart most of the day, and they didn't get a chance to chart. LPN #2 also stated she had checked on the resident at 6:00 AM on 5/25/15 but later in the interview said, "The lab tech came to do a lab draw and came out of the room around 7:55AM and said he/she thought the resident had passed away." Medical record review of the Medical History and Physical Examination dated 2/24/15, revealed "...Physical Exam: Alert and Oriented checked, with the handwritten added comment "x 2," No Acute distress checked, "fair" judgment and insight checked..." Telephone interview with the Physician, contacted by the Administrator, on 5/28/15 at 10:00 AM, confirmed the Physician remembered the resident but did not remember the circumstances related to his death "without having the chart in front of me." Interview with the Director of Nursing (DON) on	F 514	Newly-hired nurses will be educated by the ADON during their orientation period addressing the facility Charting and Documentation Policy; which includes following facility policy for routine charting, the need to document in the medical record any pertinent changes in residents' condition, and times of notifications of family and physician. <u>Monitoring</u> A monthly audit to ensure the facility Charting and Documentation Policy is being followed will be conducted by the MDS Coordinator. This audit will include following facility policy for routine charting, the need to document in the medical record any pertinent changes in residents' condition, and times of notifications of family and physician. The results of this audit will be presented by the MDS Coordinator to the monthly Quality Assurance Performance Improvement Committee for review and recommendations until the goal of 100% compliance is met for 3 consecutive months; then quarterly. The QAPI Committee consists of the Administrator, Medical Director, Director of Nursing, Asst. Director of Nursing, Dietary Manager, Housekeeping Supervisor, Medical Records Coordinator, Social Services Director, Activities Director, Business Office Manager, Human Resources	6-30-15

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F 514	Continued From page 7 5/28/15 at 12:10 PM. in the DON's office confirmed the facility failed to document changes in the resident's condition, times of notifications of family and the physician, and the medical record was incomplete.	F 514	Manager, Maintenance Director and Rehab Manager and MDS Coordinator.	